SPECTERA
A UnitedHealth Group Company

Baltimore, MD

Effective Date: _____/_____/_____
Group # : _____(For Office Use Only)

Vision Plan Enrollment Form
State of Wisconsin Central Payroll Employees

If you are currently enrolled, coverage will continue automatically. You do not need to complete a new application.

I. Check the Appropriate Boxes - - - Please Keep a Copy for Your Records - - -

Coverage Desired (all rates are monthly)

- ☐ Employee Only $ 5.40
- ☐ Employee + Spouse $10.50
- ☐ Employee + Child(ren) $11.00
- ☐ Employee + Family $16.50

- ☐ New Enrollment
- ☐ Change of Status / Address
- ☐ Cancel Coverage Effective 12/31/04

REASON FOR CHANGE IN STATUS

- ☐ Termination
  Terminated employment on _____/_____/_____ and declines COBRA offer.
- ☐ Marriage (please include date of marriage)
  _____/_____/_____
- ☐ Dependent child married/reached age limit, or no longer dependent.
- ☐ Death date: _____/_____/_____
- ☐ Divorce date: _____/_____/_____
- ☐ Last Name/Address Change
- ☐ Adoption of child, date:
  _____/_____/_____
- ☐ Retired, date paid through:
  _____/_____/_____
  To continue coverage I understand I will be billed a single payment to cover premium for the balance of the year.

II. Employee Information (please print clearly):

Social Security Number _____ - _____ - _____

Your Name _____
(First) (Middle Initial) (Last)

Birth Date _____/ _____/ _____

Address _____

_____

Home Phone (_____) _____ - _____ Work Phone (_____) _____ - _____

III. List All Eligible Family Members Below (if electing dependent coverage):

	First Name	Last Name	Birth Date	Full Time Student?	Sex
Spouse			___/___/___	not applicable	☐M / ☐F
Child			___/___/___	☐ Yes ☐ No	☐M / ☐F
Child			___/___/___	☐ Yes ☐ No	☐M / ☐F
Child			___/___/___	☐ Yes ☐ No	☐M / ☐F
Child			___/___/___	☐ Yes ☐ No	☐M / ☐F

I agree to continue enrollment in the vision plan until the next open enrollment cycle and authorize you to deduct premiums from my payroll for vision care services in future periods. To cancel my coverage, I must submit a request for cancellation prior to December 1 to cancel coverage beginning January1 of the following year.

*Your Signature*_____ *Date*_____

Spectera provides services under the following regulated subsidiaries in the following states: Spectera Vision Inc.; Maryland - Spectera Insurance Company